| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155139 | A. BUILDING _____ B. WING _____ | C 01/24/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **NORTH WOODS VILLAGE** | **2233 W JEFFERSON ST KOKOMO, IN 46901** |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 000 | INITIAL COMMENTS<br><br>This visit was for the Investigation of Complaint IN00123040.<br><br>This visit was in conjunction with the investigation of Complaint IN00122596.<br><br>This visit was in conjunction with the Recertification and State Licensure Survey.<br><br>Complaint IN00123040- unsubstantiated, due to lack of evidence.<br><br>Survey dates: January 14, 15, 16, 18, 22, 23, and 24, 2013.<br><br>Facility number: 000064<br>Provider number: 155139<br>AIM number: 100288770<br><br>Survey team:<br>Michelle Carter, RN, TC<br>Rita Mullen, RN<br>Tammy Alley, RN (January 14, 15, 16, 18, 22, 23, 24, 2013)<br><br>Census bed type:<br>SNF: 17<br>SNF/NF: 143<br>Total: 160<br><br>Census payor type:<br>Medicare: 36<br>Medicaid: 94<br>Other: 30<br>Total: 160<br><br>Sample: 5 | F 000 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 155139 | A. BUILDING _____ B. WING _____ | C 01/24/2013 |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 000 | Continued From page 1<br><br>North Woods Village was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2 in regard to the investigation of Complaint N00123040.<br><br>Quality Review completed by Tammy Alley RN on 1/30/2013 | F 000 | | |